State Flexibility for Medicaid Benefits: Final Rule

Center for Medicaid, CHIP and Survey and Certification (CMCS)
May 2010

BACKGROUND

- Section 6044 of the Deficit Reduction Act (DRA) of 2005 created new section 1937 of the Social Security Act
- Increased flexibility for States to provide Medicaid coverage through "benchmark" or "benchmarkequivalent" benefit packages
- Limited to certain groups of Medicaid beneficiaries
- Changes enacted by CHIPRA and the Affordable Care Act

Benchmark Options

- Federal Employees Health Benefit Plan Equivalent Coverage
- State Employee Health Benefit Coverage
- Commercial Health Maintenance Organization Plan
- Secretary-approved Coverage

Key CHIPRA Clarifications

- EPSDT required for children under age 21
 - EPSDT can be provided through a benchmark/benchmark-equivalent and/or as an additional benefit
- Clarifies applicability of title XIX rules such as freedom of choice, comparability, statewideness and assurance of transportation services

Health Reform Changes

The Affordable Care Act

REQUIRED EFFECTIVE MARCH 23, 2010:

- Services provided to newly eligible adults with incomes at or below 133% FPL must consist of benchmark or benchmark-equivalent coverage even if the state has not elected to provide benchmark coverage.
- Benchmark and benchmark-equivalent benefit coverage for all enrollees must include family planning services and supplies and comply with mental health parity.
- Benchmark-equivalent coverage must also include prescription drugs and mental health services.
- Additional Final Rule making these changes is forthcoming and will be effective July 1, 2010.

REQUIRED EFFECTIVE JANUARY 1, 2014:

Coverage of "essential health benefits" that apply to Exchange coverage.

Key Objectives

- Flexibility for States to establish benefits packages; and
- Ensuring beneficiary access to needed services

"Benchmark-Equivalent" Defined

Must include the following services:

- Inpatient and outpatient hospital
- Physicians' surgical and medical
- Lab and x-ray
- Well baby/well child care (including immunizations)
- Emergency services*
- Family planning services and supplies*
- Other appropriate preventive services, as determined by the Secretary

* = Added to 4/30/10 final rule

Exempt Populations

- Child welfare or in foster care (definition clarified*)
- Medically needy
- Pregnant women
- Blind or disabled
- People receiving emergency Medicaid
- Inpatients in a hospital nursing facility, ICF/MR, or other medical institution, and are required to spend down income

- Individuals who qualify for LTC services
- Individuals with Tuberculosis
- Medicare beneficiaries
- Women with breast/cervical cancer
- Parents or caretakers under section 1931 (definition clarified*)
- Individuals who are medically frail or have special medical needs (new minimum definition of this group*)
- Individuals receiving hospice care

* = Clarified in 4/30/10 final rule

Voluntary Enrollment Permitted but Protections Required:

- Enrollee must be provided comparison between the standard plan and benchmark
- Enrollee may request to return to the standard plan at any time; timely processing; access to all plan services pending disenrollment
- State required to track enrollments and disenrollments

Transparency

- States must provide public notice before proposing benchmark plans/changes to approved plans
- CMS must post on its Website approved benchmark/benchmark-equivalent plans that contain provisions of title XIX that CMS decided do not apply (CHIPRA-required change)

Access to FQHC Services

- States must assure enrollee access -- through benchmark coverage or otherwise -- to rural health clinic services and FQHC services
- Payments must be made in accordance with the Medicaid payment provisions for rural health clinics and FQHC services

Current Status

- Final Rule published on April 30, 2010
- Effective date July 1, 2010
- 8 States have implemented benchmark benefit plans:
 - Virginia
 - Kentucky
 - Idaho
 - Kansas
 - New York
 - Washington
 - Wisconsin
 - West Virginia